

**MEDICAID INTERIM COMMITTEE:
SUMMARY OF STUDIES, LEGISLATION RECOMMENDED,
AND OTHER ACTIONS, 2006 – 2007**

Source:

2007 LEGISLATIVE INTERIM REPORT

A report to the 57th Legislature on
recommended legislation and studies
from the 2007 Legislative Interim Committees
(pp. 10, 11, 81-86)

Office of Legislative Research and General Counsel
January 2008

RECOMMENDED LEGISLATION

Medicaid 340B Drug Pricing Programs, H.B. 74 - This bill requires the department to explore the feasibility of expanding the use of 340B drug pricing programs in the state Medicaid program; requires the department to report to the Legislature's Health and Human Services Interim Committee and Health and Human Services Appropriations Subcommittee regarding implementation of the expansion of the 340B drug pricing program; and sunsets the section on July 1, 2013 (page 84).

Medical Benefits Recovery Amendments, S.B. 50 - This bill defines terms; recodifies the Medical Benefits Recovery Act; modifies provisions related to recovery of medical assistance from a recipient's estate or a trust, so that recovery can be made as soon as an exception to recovery, relating to a surviving spouse or child, is no longer in effect; provides for the imposition of a lien, authorized by the federal Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), against the real property of a person who is an inpatient in a care facility, during the life of that person; establishes procedures, requirements, and exemptions, relating to imposing a TEFRA lien; establishes a rebuttable presumption that a person who is an inpatient in a care facility cannot reasonably be expected to be discharged from the care facility and return to the person's home, if the person has been an inpatient in a care facility for a period of at least 180 consecutive days; provides for review and appeal of a decision to impose a TEFRA lien; provides for the dissolution and removal of a TEFRA lien; provides that an agency that the department contracts with to recover funds paid for medical assistance under the Medical Benefits Recovery Act shall be the sole agency that imposes or removes a TEFRA lien; and makes technical changes (page 86).

Notice of Changes to the State Medicaid Plan, H.B. 82 - This bill clarifies the content of the Department of Health's notice to the Legislature when the department makes a change to the state Medicaid plan; and makes technical and clarifying changes (page 85).

MEDICAID INTERIM COMMITTEE**Membership**

Sen. Allen M. Christensen, Senate Chair
Rep. Merlynn T. Newbold, House Chair
Sen. Gene Davis
Sen. Lyle W. Hillyard
Sen. Sheldon L. Killpack
Sen. Ross I. Romero
Rep. Stephen D. Clark
Rep. Tim M. Cosgrove
Rep. Bradley G. Last
Rep. David Litvack
Rep. Michael E. Noel
Rep. Paul Ray

Staff

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Danny Schoenfeld, Fiscal Analyst
Gary Syphus, Fiscal Analyst
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Catherine J. Dupont, Associate General Counsel
Thomas R. Vaughn, Associate General Counsel
Phalin L. Flowers, Legislative Secretary

OVERVIEW

As in many other states where commissions or other groups have been created in recent years to study Medicaid, the Legislature created the Medicaid Interim Committee in 2006 to identify ways to reduce the high rate of spending growth and federal partnership that pays for health care services to many of Utah's expectant mothers, aged, and disabled.

ACCOUNTABILITY**Background**

The Deficit Reduction Act of 2005 authorizes state Medicaid programs to create "health opportunity accounts," increase copays, and vary services across populations. These provisions, however, are limited to certain groups of enrollees. Prior to the Deficit Reduction Act, some states adopted similar provisions under waivers.

During the 2006 and 2007 interims, the Committee reviewed actions taken by other states to link individual enrollee behavior to program benefits and costs and recommended that a pilot program for health opportunity accounts be studied and established.

Action

The Committee considered this issue at its January 5, November 20, and December 12, 2007 meetings, but did not recommend draft legislation.

CONSOLIDATION OF MEDICAID ELIGIBILITY SERVICES**Background**

In the past, Medicaid eligibility was determined by two state agencies, the Department of Health and the Department of Workforce Services. During the 2006 interim, the Committee considered a proposal to consolidate all eligibility functions under the Department of Workforce Services. The proposal was expected to simplify the eligibility process for potential enrollees, reduce spending on duplicate office space, and perhaps result in some long-term cost avoidance. In January 2007, the Committee recommended that the Commerce and Workforce Services Appropriations Subcommittee and the Health and Human Services Appropriations Subcommittee consider the proposal for the 2007 General Session. Both committees studied the proposal and the Legislature approved the consolidation, transferring funding from the Department of Health to the Department of Workforce Services for 255 full-time equivalent employees, 10 offices, and 10 vehicles.

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Action

The Committee considered this issue at its January 2007 meeting, but did not recommend draft legislation.

HEALTH AND HUMAN SERVICES PROGRAMS GENERALLY

Background

Prior to focusing its attention on Medicaid, the Committee reviewed spending trends across all health and human services programs. During the 2006 interim, the Committee conducted a survey of 177 health and human services programs delivered by:

- the Department of Health;
- the Department of Human Services;
- the Department of Workforce Services;
- the State Office of Rehabilitation; and
- the Utah Schools for the Deaf and Blind.

Through the survey, the Committee collected data on eligibility, expenditures, clients served, federal requirements, and the potential impacts of increasing, decreasing, or eliminating state funding. The Committee also received testimony from persons representing consumers, providers, and program administrators of various health and human services programs on how to manage program costs and increase consumer accountability.

Action

The Committee considered this issue during the 2006 interim, not during the 2007 interim, and did not recommend draft legislation in either year.

LIMIT ON OVERALL SPENDING GROWTH

Background

Although Medicaid enrollment has declined somewhat from the levels experienced during the recent economic down turn and annual spending growth has dropped into the single digits, the program is expected to continue its long-term pattern of growing much faster than its revenue sources and other areas of the state budget.

During the 2006 interim, the Committee received reports from staff on the potential growth of future Medicaid budgets and reviewed strategies used by other states to constrain program costs.

In January 2007, the Committee recommended that the Legislature limit the growth in state funding for Medicaid to five percent in FY 2008. State funds appropriated to Medicaid for FY 2008 during the 2007 General Session were approximately three to four percent greater than the amount appropriated for FY 2007.

In January 2007, the Committee also recommended:

- an "acceptable growth" formula be developed and used by the Legislature in future sessions to limit Medicaid growth (among other factors, the formula should recognize the economic impact of the program);
- a precise Medicaid mission statement be developed by either the Medicaid Interim Committee or the Health and Human Services Appropriations Subcommittee and used to prioritize services;
- the Department of Health and the Department of Human Services explore options for reducing Medicaid costs and report their findings to the Health and Human Services Appropriations Subcommittee;
- the Department of Health implement an electronic medical record system for Medicaid and issue a request for proposals to find out whether vendors would be willing to accept payment for developing and implementing the system on a percentage of savings basis; and
- the state consider the offer by Digital Healthcare to conduct a no-cost audit of Medicaid prescription drug purchases to determine the amount of potential cost recovery from third party payers.

During the 2007 General Session, in an attempt to provide services in a more cost effective manner, the Legislature earmarked \$174,000 of the amount appropriated to Medicaid in FY 2008 for a capitated adult vision program, pending federal approval.

Action

The Committee considered this issue during the 2006 interim and at its January and October 2007 meetings, but did not recommend draft legislation.

LONG-TERM CARE**Background**

Nationally, the aged and persons with a disability make up only 25 percent of Medicaid's enrollment but account for 70 percent of its costs. In Utah, a similar pattern exists. The Committee studied what could be done to reduce the costs associated with these populations, particularly in the area of long-term care services. The Committee received suggestions from many stakeholders, including consumers, providers, and state and local agencies responsible for funding many of these services.

The Committee focused on four areas believed to have potential to reduce long-term care spending: (1) increasing the use of long-term care insurance; (2) increasing the use of home and community based services; (3) reducing nursing home capacity; and (4) prohibiting the future construction of nursing care facilities that derive a majority of their revenue from Medicare patients.

Long-term care insurance is still a relatively new product and not widely used like other forms of insurance. States have used tax incentives to promote the purchase of long-term care insurance. In Utah, taxpayers have been able to deduct their long-term care insurance premiums since 2000. However, that deduction was not carried forward as a credit against the new flat income tax. The Committee discussed whether the new flat tax should include a credit for premiums paid for long-term care insurance.

Nationwide, there has been much discussion about "rebalancing" the long-term care system so that services otherwise provided in nursing homes are provided in home and community based settings where appropriate. The Committee considered a proposal by the Division of Aging and Adult Services to increase placement in home and community based settings. The proposal would create a pilot program that: (1) trains discharge planners in one

hospital from each of the major hospital chains about home and community placement options; and (2) sets aside funding so that placement slots are available specifically for those hospitals.

Funding three slots per hospital per month would cost approximately \$320,000 in state funds. By contrast, funding the same number of slots in nursing homes would cost approximately \$1,300,000 in state funds. The Committee recommended that the proposal be sent to the Health and Human Services Appropriations Subcommittee.

On the whole, Utah nursing homes appear to be operating at excess capacity. Some believe that reducing overall capacity would decrease Medicaid expenditures. Although Utah caps the number of nursing home beds that may be certified for use by Medicaid patients, an exemption permits individual facilities to expand capacity by up to 30 percent each year under certain conditions. The Committee studied the criteria for granting Medicaid certification and the formula used to reimburse nursing homes for long-term care.

During the 2007 General Session, the Legislature imposed a moratorium on the construction of nursing care facilities that derive a majority of their revenue from Medicare patients. The moratorium is scheduled to expire July 1, 2009. The Committee considered whether the moratorium should be extended.

Action

The Committee considered this issue during the 2006 interim and at its July 20, September 7, October 3, November 2, November 20, and December 12, 2007 meetings and recommended that the sunset date for *Utah Code 26-21-23*, which governs the licensing of a new nursing care facility and the licensing of additional beds within an existing nursing care facility, be extended to July 1, 2011.

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PHARMACEUTICALS—340B DRUG PURCHASING PROGRAM

Background

Several years ago the Utah Medicaid program arranged for enrollees with hemophilia to purchase their medications through the federal 340B drug program. The 340B drug program allows prescriptions to be purchased at a price sometimes lower than the Medicaid price through federally qualified health centers, disproportionate share hospitals, and other qualified entities. During the 2007 interim the Committee studied whether other Medicaid enrollees could be added to the 340B program. The Committee considered draft legislation, "Medicaid 340B Drug Pricing Programs," which requires the Department of Health to explore the feasibility of expanding use of the 340B program and report to the Legislature.

Action

The Committee considered this issue at its July 20, September 7, November 2, and November 20, 2007 meetings and recommended draft legislation, "Medicaid 340B Drug Pricing Programs."

PHARMACEUTICALS—AVERAGE MANUFACTURER'S PRICE

Background

Federal Medicaid law requires that payment to a pharmacist for a prescription drug sold to a Medicaid enrollee be made in two parts: (1) a reimbursement to cover the pharmacist's cost of acquiring the drug; and (2) a dispensing fee to cover the pharmacist's costs associated with dispensing the drug, i.e., overhead and profit. Historically, reimbursement to Utah pharmacists has been a percentage of the AWP (average wholesale price), subject to several other limits. Recent federal action has provided states with a new measure for either calculating or limiting reimbursements—the AMP (average manufacturer's price). The Department of Health has been considering the impact of adopting AMP as a basis for determining pharmacy reimbursement.

The Committee received testimony from the following on the impact of adopting AMP as a basis for determining pharmacy reimbursement:

- Utah Pharmacists Association,
- National Association of Chain Drug Stores,
- Department of Health,
- Medicaid Fraud Control Unit, and
- Office of the Legislative Fiscal Analyst.

The Committee discussed how to adequately reimburse low volume pharmacies while not overcompensating high volume pharmacies.

Action

The Committee considered this issue at its July 20, September 7, and November 2, 2007 meetings, but did not recommend draft legislation.

PHARMACEUTICALS—GENERAL

Background

Notwithstanding the mandatory use of generic drugs and other strategies implemented by the Department of Health, pharmaceutical spending is the fastest growing component of Utah's Medicaid program. During the 2006 and 2007 interims, the Committee reviewed utilization control and cost containment strategies employed by the Department of Health, other states, and the private sector to reduce the growth in spending on Medicaid pharmaceuticals. These strategies included additional use of the federal 340B drug program, limiting payment for pharmaceuticals to a percentage of average manufacturer's prices, and implementing a preferred drug list.

Action

The Committee considered this issue during the 2006 interim and at its January, July, and September 2007 meetings, but did not recommend draft legislation.

PHARMACEUTICALS—PREFERRED DRUG LIST**Background**

During the 2006 interim, the Committee studied whether to institute a Medicaid PDL (preferred drug list) to reduce pharmaceutical cost increases. The Committee concluded that additional study was needed. During the 2007 General Session, the Legislature authorized use of a PDL with the passage of S.B. 42, "Preferred Prescription Drug List."

Following the 2007 General Session, the Committee reviewed the rules proposed by the Department of Health to implement the PDL. The PDL went into effect October 1, 2007, and is expected to reduce the growth of General Fund spending on pharmaceuticals by \$1.3 million in FY 2008. Initially, the PDL applied to only statins and proton pump inhibitors. On December 1, 2007 the PDL was expanded to include oral hypoglycemics and diabetic supplies. By the end of FY 2008, the PDL is expected to include several other classes of drugs.

S.B. 42 prohibits the Department of Health from including psychotropic and anti-psychotic drugs on the PDL. The Committee discussed narrowing the exclusion for psychotropic drugs, which may be unduly broad.

S.B. 42 also allows a physician to override the preferred drug list by documenting medical necessity and writing "dispense as written" on the prescription. The Committee studied, but did not recommend, whether to replace the physician override with a provision requiring prior authorization from the Department of Health. Use of prior authorization would likely decrease the use of drugs not on the PDL and thus reduce pharmaceutical spending.

Action

The Committee considered this issue during the 2006 interim and at its January, July, and September 2007 meetings, but did not recommend draft legislation.

OTHER STUDIES**Legislative Oversight**

In 2003, the Legislature required the Department of Health to report to the Executive Appropriations Committee or the Health and Human Services Appropriations Subcommittee whenever the Department implements a change in the Medicaid State Plan, initiates a new Medicaid waiver, submits an amendment to an existing Medicaid waiver, or initiates a rate change requiring public notice under state or federal law. The report must include the proposed change in services or reimbursement; the effect of an increase or decrease in services or benefits on individuals and families; the degree to which any proposed cut may result in cost-shifting to more expensive services in health or human service programs; and the effect of any proposed increase of benefits or reimbursement on current and future appropriations from the Legislature to the Department. In 2003, the requirement was modified slightly to require the Department to report whenever an amendment to an existing Medicaid waiver is initiated, rather than submitted.

The Committee considered draft legislation, "Notice of Changes to the State Medicaid Plan," that would clarify the Department's reporting requirements by requiring any report to include:

- a description of the Department's current practice or policy that the Department is proposing to change;
- an explanation of why the Department is proposing the change;
- the effect the proposed change may have on federal matching dollars received by the state Medicaid program;
- any costs shifting or cost savings within the Department's budget that may result from the proposed change; and
- identification of the funds that will be used for the proposed change, including any transfer of funds within the Department's budget.

The Committee considered this issue at its December 2007 meeting and recommended draft legislation, "Notice of Changes to the State Medicaid Plan."

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Pharmaceutical Litigation

The MFCU (Medicaid Fraud Control Unit) within the Office of the Attorney General reported that it has filed law suits against several pharmaceutical manufacturers to recover reimbursement payments, alleging that the manufacturers used inflated average wholesale prices to market their products.

MFCU also reported that the state has filed suits against Eli Lilly and Merck for failure to warn the public of known risks associated with two drugs, Zyprexa and Vioxx.

The Committee considered this issue at its October 3 and November 20, 2007 meetings, but did not recommend draft legislation.

Reauthorization of the Medicaid Interim Committee

The Committee discussed its accomplishments and whether it should continue its work for an additional year. The Committee considered this issue at its December 2007 meeting and recommended that the Legislative Management Committee reauthorize the Medicaid Interim Committee in 2008.

Recovery of Long-term Care Benefits

Existing law allows the Department of Health to recover the value of Medicaid benefits provided to a recipient 55 years of age or older by imposing a lien on the recipient's estate or trust if the recipient does not have a surviving spouse or does not have a child who is under 21 years of age, blind, or permanently and totally disabled. In practice, the Department is often unable to recover the value of benefits provided because a recipient's heirs liquidate the estate or trust before the Department is able to complete the recovery process. To avoid this problem, many states have authorized use of liens against the real property of a Medicaid recipient who has become permanently institutionalized. The Committee considered draft legislation, "Medical Benefits Recovery Amendments," that would allow the use of these liens, authorized under federal law and called TEFRA (Tax Equity and Fiscal Responsibility Act of 1982) liens, to notify potential heirs of the recovery process and provide notification to the state of any attempt to transfer the property once a

Medicaid recipient has become permanently institutionalized for at least 180 days.

The Committee considered this issue at its November 20 and December 12, 2007 meetings and recommended draft legislation, "Medical Benefits Recovery Amendments."